Bringing Adolescents into Substance Abuse Treatment Through Community Outreach and Engagement: The Hartford Youth Project*

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Abstract—While outreach and case management services have been shown to improve retention of at-risk youth in behavioral health treatment, these important support services are challenging to implement. The Hartford Youth Project (HYP), established by the Connecticut Department of Children and Families as a pilot for the state adolescent substance abuse treatment system, made outreach and engagement integral to its system of care. HYP brought together a network of stakeholders, referred sources, juvenile justice, schools, community agencies, child welfare, and families; community-based outreach agencies; treatment providers; and administrative service organizations responsible for project coordination. Culturally competent Engagement Specialists located in community agencies were responsible for cultivating referral sources, community outreach, screening and assessment, engagement of youth and families in treatment, case management, service planning, recovery support, and advocacy. This article describes HYP's approach to identifying and engaging youth in treatment, as well as its challenges. Use of family-based treatment models, expectations of referral sources, limited service capacity, youth and family problems, and staff turnover were all factors that affected the outreach and engagement processes. Process, baseline assessment, and case studies are used to describe the needs and issues specific to Hartford's substance-abusing Latino and African-American youth.

Keywords—adolescent, outreach, substance abuse treatment

Throughout the 1990's, substance use among adolescents increased nationwide while the age of initiation decreased, putting more youth at risk of developing long-term substance abuse and dependence (Johnston, O'Malley & Bachman 2002). While there are indications that the rates of substance use have declined in recent years, they remain high.
In 2005, the National Household Survey of Drug Use and Health (NSDUH, SAMHSA 2006) found that 16.5% of 12- to 17-year-old youth were current alcohol users and 9.9% reported use of marijuana, the most commonly used illicit drug. This national survey also revealed that 8.0% of youth aged 12 to 17 met criteria for substance abuse or dependence. However, less than one in ten (8.5%) identified with abuse or dependence on substance abuse treatment at a specialty facility, indicating the large gap between treatment need and service use.

In the national data, adolescents living in the Northeast and in socioeconomically disadvantaged urban centers are at particularly high risk for marijuana and other illicit drug use (SAMHSA 2006). Data from the NSDUH, as well as state-specific data, bear out this reality for Connecticut. Historically, Connecticut adolescents aged 12 to 17 have had higher rates of use than the national averages for both alcohol and marijuana. A statewide school survey conducted in 2000 showed that 52% of Connecticut’s tenth graders reported using alcohol compared to 41% of their peers nationwide as reported by the Monitoring the Future survey (Ungemack, Cook & Dannen 2001). The rate of marijuana use among tenth graders was 26% compared to 20% statewide for that year. It is noteworthy that marijuana and alcohol are the primary problem substances for youth entering substance abuse treatment (Dennis et al. 2002).

In Connecticut, a series of substance abuse treatment needs assessment studies, including a statewide school survey and targeted studies of at-risk youth, were conducted between 1993 and 2004 to estimate treatment needs in the state. Based on a 1995 statewide school survey, it was estimated that 9% of the state’s senior high school students and 4% of junior high school students gave sufficient evidence of substance-related behaviors and problems to warrant a more detailed evaluation for substance use disorder (Ungemack, Hartwell & Boroz 1997). The most frequent behaviors such as juvenile arrests, incarcerated youth, alternative school students and school dropouts and chronic truants, had inflated rates of treatment need compared to youth who were captured by school surveys. One-third of juvenile arrestees met criteria for substance abuse and dependence, and most of these were substance dependent found to have high rates of family distress, psychiatric problems (i.e., depression, suicidal ideation), school disengagement, and risky sexual behaviors associated with contracting HIV (Schottefield et al. 1996). More than half (53%) of incarcerated adolescents who were determined to have met criteria for substance abuse or dependence, mostly attributable to marijuana use (Ungemack, Delahorne & Blitz 1998). Need for treatment was associated not only with age, but also with gender, ethnicity (i.e., Hispanics evidenced higher rates of use than either White or Black students), and type of community. When data from both in-school and out-of-school populations were taken into account, the estimated rate of treatment need in large, socioeconomically disadvantaged urban centers such as Hartford was 11% compared to 6% statewide (Ungemack, Delahorne & Cook 2000). According to a report of the Connecticut Alcohol and Drug Policy Council (2002), approximately 15,000 youth in Connecticut were estimated to be in need of substance abuse treatment or early intervention.

There are many reasons why youth, like adults, do not receive substance abuse treatment. Lack of a perceived need for treatment is the most often cited reason for not obtaining substance abuse treatment services. According to analyses of data from the 1995 and 2004 NSDUH surveys, 56.6% of adolescents with a need for alcohol treatment and 87.4% of those meeting criteria for illicit drug abuse or dependence did not perceive a need for treatment (SAMHSA 2006). Other commonly mentioned explanations for not receiving treatment include: financial barriers; stigma concerns; embarrassment or fear about getting treatment; lack of knowledge about available programs; insufficient availability of treatment slots; and other access issues, such as lack of transportation or childcare and not being able to get time away from ongoing responsibilities to attend treatment (SAMHSA 2006). These barriers to treatment affect parents/caregivers of substance-abusing youths, if not the children themselves.

In communities of color, a variety of additional factors affect both the perception of service need and access to those services. Research has shown that perception of mental health treatment need can vary by race or ethnic background, suggesting that different criteria are being used to identify problem behaviors among different cultural groups (Shude 2005). Research by McMeiner and Weitz (1996) found that Afro-American and Hispanic parents of children with identified emotional and behavioral problems were less likely than non-Hispanic White parents to perceive the need for or to seek professional help for their children’s behavioral health problems. Many in communities of color question the cultural appropriateness of existing services or express preferences for nontraditional interventions more in keeping with their cultural values and institutions (Gunn & Turegio 2002). Access to health services can be impeded by the actual and perceived cultural sensitivity of available services, including linguistic compatibility or fit of the intervention services with the health beliefs and values of the community. Another potential barrier to services is a lack of conviction about the efficacy of mental health or substance abuse treatment, which has also been shown to vary by cultural background (Bussing et al. 2003). Further, many in minority communities have a "healthy cultural suspicion" of mainstream institutions due to personal experiences or awareness of prejudice and maltreatment towards minority groups (Nyberg & Franklin 2005). Whaley (2001) suggests that cultural mistrust can especially impact the attitudes and behaviors of African-Americans when it comes to accessing mental health services. Indeed, some evidence seems to justify this variance. In their study of service placement patterns by racial background, Stepphard and Benjamin-Coleman (2001) found that Black youth were three times more likely to be remanded to detention centers compared to White youth who were more frequently hospitalized for comparable emotional and behavioral disturbances. The perceived consequences of admitting to use of illicit drugs or alcohol abuse, especially with respect to criminal justice or child welfare, may also influence individuals’ willingness to seek treatment for themselves or family members (Anderson et al. 2006).
Engagement Specialists (ES), hired by and located in two community-based agencies (Urban League of Greater Hartford and Hispanic Health Council), obtained referrals from juvenile justice agencies, schools and other community resources, and then linked the youths and families to treatment offered by several different provider agencies, as well as wrap-around support services available in the community. The ESs work on a wide array of issues to bolster and maintain engagement of substance-abusing youths and their families so that they could receive needed services. These interventions included motivational interviewing, referral sources; community outreach to youths, schools, providers, and youth-serving agencies; screening and assessment; engagement of youth and families; case management; service planning; treatment and recovery support; and advocacy. The ESs, who worked with the adolescents and their families throughout treatment and up to one year after their initial assessment, also conducted follow-up interviews.

This article describes the HYP’s approach to identifying and engaging youth in treatment through the use of Engagement Specialists (ES). It discusses the successes and challenges HYP experienced in implementing this part of the initiative.

THE HYP MODEL

Relationship-building, collaboration, needs assessment, and individualized family-focused treatment were the guiding principles underlying HYP’s system of care, and they were demonstrated at the agency, staff and practice levels.

Agencies

Community-based outreach agencies. Because its central mandate is child welfare, DCF is often mistrusted by members of the state’s communities of color even though the agency is responsible for funding and providing a myriad of services benefiting children and youth. To help ameliorate its negative public image and to ensure that the two major population groups—Hispanics and Blacks—were reached by HYP, DCF collaborated with two community-based agencies with long histories of service to the Hartford community, the Hispanic Health Council and the Urban League of Greater Hartford. Both are based in or near the communities they serve, enhancing geographic accessibility as well as the comfort level of their clients. Both agencies are multivisit service organizations that are trusted and well-recognized by community members for social, educational, vocational and prevention services. The agencies’ histories of providing outreach services to Hartford families, DCF worked collaboratively with management staff from the community agencies before and during the project to develop and refine the HYP outreach and engagement model. The community agencies’ input helped ensure that the service-delivery model was culturally responsive, a key aspect of effective collaboration. The community agencies were also responsible for staffing the outreach component of HYP and providing on-site daily supervision of the ESs.

DCF and its community collaborators designed HYP so that youth and their families would be quickly and continuously supported as services were needed as part of the intervention to facilitate treatment gains. These ancillary support services included: assistance with housing, medical care, mental health care and financial crises; legal counseling; vocational counseling; educational support; transportation; and childcare. These supportive services were considered to be as important to treatment success as the treatment services themselves. The two outreach agencies either directly offered services or had relationships with other community-based organizations that offered a variety of supportive services for families. The ESs developed, and regularly updated, a comprehensive inventory of community-based organizations and resources available to HYP clients as supportive services.

Referral source linkages. For HYP to be successful, it was critical for the ESs to establish relationships with agencies with access to the target population. Without these relationships, reaching substantial numbers of youth in need of treatment would have been difficult. Beginning in the first year of the project, the HYP Project Coordinator and the ESs developed and implemented a strategy to market HYP to the leadership and staff of these community organizations and groups, including: school social workers; principals; Board of Education members; Hartford’s juvenile pretrial department; parole officers; DCF caseworkers; and task forces and grassroots organizations serving the city’s youth and families. Through face-to-face meetings and informal personal contacts, the HYP staff described the project and the treatment and support services available to substance-abusing youth and their families. The HYP staff engaged potential referral sources in discussions about how they could work together to benefit the youth and their families. These discussions enhanced the referral sources’ buy-in regarding the value of adolescent treatment services and helped build successful relationships between HYP and the community. The ESs regularly made initial presentations to established referral sources in order to brief new staff, answer questions, or update key referral personnel. In order to build trust and foster dialogue, the ESs provided status updates on referred youth and their families, as appropriate, within client confidentiality constraints. Due to the access of these sustained efforts, the ESs eventually had to do less street outreach and direct solicitation of referrals in order to obtain clients. Referrals began to flow in via phone calls, emails, and faxes, which allowed the ESs to focus their time and efforts in other areas.

Project coordination. As described above, DCF had brought together a network of stakeholders to build HYP’s system of care. The ES and the treatment staff, the stakeholders with the most client contact, were employees of their independent host agencies, including the two outreach agencies and five Hartford-based substance abuse treatment agencies: The Village for Families and Children (The Village); Hartford Behavioral Health (HBBH); Community Solutions, Inc. (CSHI); Alcohol and Drug Rehabilitation Clinic (ADRC); and North American Families Institute (NAFI). DCF contracted with each agency to provide services for HYP youth and their families. The ESs worked closely on HYP, but most treatment providers served HYP clients via dedicated treatment slots while providing clinical services to other non-HYP clients.

It was an added complication that the evidence-based and manualized family-based models used by agencies serving HYP clients (particularly MST and MDFT) called for providing comprehensive case management similar to that of the ESs. Early in the project, DCF convened the treatment providers and the model developers to define how best to include the ES in the intervention without sacrificing the fidelity of the clinical treatment protocols. DCF, as the lead entity, brokered these discussions to determine the appropriate level and type of ES involvement to maximize positive treatment outcomes without undermining the integrity of the treatment model. The ES case management component was designed as true wrap-around service, active before, during and after treatment. During treatment, the ESs functioned as a key resource as needed to address problems in keeping the youth and family in treatment, allowing the clinical program’s own case manager to assume more of a therapist mission role to directly support treatment.

Another strategy the HYP Project Coordinator used to foster collaboration and coordinate care was to establish monthly meetings between the ESs and treatment providers. These meetings helped the ESs and treatment providers formulate a better understanding of their youth and families’ needs and develop coordinated intervention strategies. Over the course of the project, the treatment providers and ESs began to see each other as valuable assets to their work through their mutual involvement with families.

Quarterly meetings were held with the entire HYP network, including the ESs, treatment providers, educators and DCF management staff. In addition to sharing project data and updates, these meetings provided an opportunity for network members to input in key decisions regarding the project and to raise issues requiring group discussion and problem-solving. These meetings led to a network identity that went beyond each member’s individual agency, fostering a greater sense of ownership and involvement in HYP.

Practice Characteristics

The Engagement Specialist role in HYP was multifaceted, involving more than simply identifying and engaging potential clients who are traditionally difficult to reach. HYP ESs were also responsible for assessment, service planning,
Bruning, Adolescents into Substance Treatment

Initially, DCP had wanted to use independent interviewers to conduct the GAIN-I assessments. However, there were challenges in identifying, training, and certifying a corps of independent interviewers who were available during key client access times. In particular, the assessment delays that resulted, the ESIs suggested that they would be best equipped to administer the GAIN-I. Given the sensitive nature of many GAIN-I items, and the youth were reluctant to share information with outside staff, even though they were clearly informed of their rights to confidentiality. Based on their role and the trust they engendered, it was thought that the ESIs could obtain the most honest, accurate, and complete data from their clients. Moreover, the time spent in assessment also facilitated relationship-building between ESIs and clients. Very few ESIs had prior experience administering a comprehensive semistructured assessment such as the GAIN-I. However, with the training and support of the evaluation team, a core group of ESIs became proficient GAIN-I interviewers.

Fostering Family Involvement. The literature suggests that the active involvement of family members in the assessment and treatment-planning process facilitates positive treatment outcomes for clients and counselors (Lilly et al. 2006). The ESIs set the tone for family involvement early in the engagement process to promote treatment initiation and retention. They scheduled and convened a service planning meeting shortly after a treatment recommendation was made and the client referral was accepted by a treatment provider. The planning meeting included the client, the parent(s) or other primary caregivers, the ES, the treatment provider, and any other person that the youth or family identified as having a significant role in the client’s life. These “other” individuals included: school representatives; social workers; probation officers; sentenced family members; friends; or treating providers, such as mental health providers or nurses. The involvement of family and key others in the planning process with the treatment provider and ES facilitated family investment in the treatment process from the beginning.

The ES led the service planning meeting as the primary contact with the family. The meeting was usually held at the outreach agency where it was more likely to be known to the youth and family. Many families had previously received services at that agency or knew others who received services and had been “treated well” by the agency. During the service planning meeting, the family and HYP staff together developed the goals and objectives of treatment, along with timelines and responsibilities for each stakeholder, including the treatment provider. The goals and objectives addressed the holistic needs of the family, such as educational, vocational, financial, housing, health, recreational or spiritual needs, in addition to the youth’s substance abuse treatment needs.

Engagement. Engagement in HYP was a dynamic, ongoing process that varied in intensity throughout the course of each adolescent’s treatment. In the beginning the ESIs were typically heavily involved with the family to help them recognize the need for treatment and services available to them; they decreased their involvement once treatment started. At a minimum, the ES stayed involved with the youth in a mentoring role and through planned monthly recreational and educational events. At times, when a client ceased being available for treatment or the family entered into a period of crisis where their ability to participate, the treatment provider or the family would ask the ES to assist in reengagement efforts or crisis intervention. The ESIs also stepped in when the family’s case-management needs were beyond those of the adolescent substance abuse treatment provider could address. In those instances where the treatment model did not have a case management component, such as MET/CBT or PSN, the ES served as the case manager for the family, working to refer the family to needed services as the client received treatment.

On occasion, the ES served as liaison between the family and the clinician when a provider had problems engaging a client or family member or a misunderstanding arose between the provider and client and/or the family. Usually, the ES was able to help clarify issues for one or both parties and facilitate relationship-building between the provider and client.

Advocacy. Advocacy is especially appropriate for underserved populations who are disproportionately affected by systemic problems that present barriers to their access to needed services and resources (Vera et al. 2005). Problems faced by HYP families included, but were not limited to: legal entanglements, health problems, lack of income, educational placement and support issues, and housing instability. The ESIs often advocated alone or in collaboration with the treatment provider to address these issues on behalf of the families of clients. It was not unusual for the ESIs to testify on behalf of clients at court hearings, help family members access necessary medical treatment, or assist families in obtaining rent assistance or disability services. These types of problems often either contributed to the client’s behavioral health issues or threatened treatment progress.

Engagement Specialist training. In order for the ESIs to effectively handle their multifaceted role within HYP, training and ongoing supervision were essential. Upon hire, all ESIs completed a two-day training that introduced them to the various aspects, objectives of the project, as well as their roles and responsibilities. The training curriculum covered: the supervisory process; management of referrals; referral response; conduct of service planning meetings; treatment models; community resources; mandated reporting requirements; ethics and confidentiality; crisis-management; and strategies for engaging youth and families. The ESIs were trained in expectations regarding the support they would provide relative to the therapy models, as well as in their responsibilities in tracking youth and administering three six- and 12-month post-treatment measures (CSAT’s Government Performance and Results Act and GAIN M-90). In a separate three-day session, the evaluation team provided the ESIs with training on administration of the GAIN instruments and then oversaw their subsequent certification in the GAIN. DCP also provided training to the ESIs in Motivational Enhancement Therapy and Seven Challenges (Schweder 2000) to further enhance their engagement and intervention skills and effectiveness.

Supervision. The demands of the outreach and engagement role in HYP required a supervision structure that afforded ongoing support. The outreach agency supervisors were responsible for the continual supervision of their resident ESIs. The Senior ES, the first line of contact staff hired by HYP who had demonstrated experience and skill in implementing the HYP model, served as a mentor for her coworkers and assisted with their ongoing training. She reported to the HYP Project Coordinator, as well as to her agency supervisor. The Senior ES was the primary gatekeeper for all referrals and the first point of contact for other ESIs in need of guidance and direction. She also acted as the key contact for scheduling of HYP-wide outreach efforts, meetings, and provisional activities for HYP youth.

The HYP Project Coordinator, an experienced clinician, was responsible for the overall supervision of the project and reported to the DCF Director of Substance Abuse Services. The Project Coordinator was responsible for making treatment recommendations based on the GAIN data and the ESIs’ qualitative input to determine the most appropriate treatment model for each youth. At the weekly case review meetings, the Project Coordinator reviewed the GAIN data and provisioned models of treatment and engagement. The Project Coordinator also provided crisis intervention recommendations to the ESIs and monitored and administrative support as needed.

The evaluation team worked closely with the Project Coordinator, ESIs and their supervisors, meeting weekly to ensure that the evaluation and intervention were closely linked and that project data were collected and disseminated in a timely manner. The Evaluation Project Director was responsible for supervising the ESIs’ tracking and GAIN administration activities.

Engagement Specialist Characteristics

While they varied in education, experience and skills, the most effective ESIs had certain key characteristics that were associated with successful outreach and engagement.

Knowledge of the community. Both informal and formal knowledge of the community were important qualifications for the ESIs. Knowledge of formal institutions and supports, such as social services, vocational and educational services, was essential, but only a beginning point. Armed with an inventory of community resources that they had created and that were fostered through personal contacts and activities.
the ESS were able to connect their clients and families with community assets, such as the faith-based organizations, family advocacy, recreation, and sports programs, and grassroots neighborhood organizations or groups working to improve their communities. These resources provided support for recovery and were seen as alternatives to substance use and other problem behaviors.

Familiarity with community statistics was another tool that helped the ESS understand their clients and the challenges they faced. These publicly available and social indicators included rates of high school graduation, truancy and dropout, employment, home ownership, poverty, crime, arrest and incarceration. These data were also a resource for engaging community stakeholders and informal sources. An awareness and understanding of the informal structures and dynamics in the community, not easily discernible to outsiders, was critical for establishing relationships with youth and their families. Examples of such structures are the drug culture, neighborhood turf, and gang affiliations. The ESS were trained to identify community barriers to meetings or involvement with the client and family in order to develop ways of circumventing those barriers and to facilitate program entry and retention. For instance, there were times when an adolescent or caregiver was uncomfortable with the idea of the adolescent coming to the ESS's office on their own because it meant traversing a neighborhood that wasn't their turf and could put the youth at risk of physical harm. More commonly, the youth and their family benefited from transportation to get to meetings or treatment. The ESS were able to provide safe transportation when needed through the use of bus tokens, taxi services, and agency-owned vans.

All of the ESSs were racially, linguistically, and ethnically representative of the communities they served. Many grew up or lived in Hartford. Being part of the neighborhood culture, ethnically as well as geographically, afforded ESSs access to their clients that would have been more challenging to obtain as "outsiders." Their ongoing presence and participation in the community, through residence, personal ties, work and recreation, increased their accessibility and effectiveness as ESSs. Each ESS had a cell phone that made it possible to reach clients during meetings and weekends, as well as during the day. The ESSs could respond quickly either in person or via phone when a youth or family was in crisis. This "on-call" availability helped build trust in the ESSs' commitment to help improve the lives of their clients. They were part of the communities they served, they were regarded as insiders by community members.

Commitment and persistence. The ESSs who were most effective in engaging and retaining families in treatment were those who did not give up if their initial engagement efforts were unsuccessful. Often, clients who seemed unresponsive were actually using a treatment barrier that, once identified, could be addressed by the ESS. Effective engagement and communication strategies involved persistence, creativity, flexibility and a willingness to seek input from colleagues and those knowledgeable of the youth, including their parent(s). Many of these components have been documented by others as critical when working with at-risk adolescents of color and their families (Boyle-Frank & Morrissey, 1999). The ESSs used a variety of strategies to engage reluctant youth and their families, such as:

- Making repeated visits or calls to the client's home at various times of day or on weekends;
- Asking family members about how best engage the adolescent, which helped reinforce the importance of the family's input and involvement;
- Meeting where the client was most comfortable, whether at home, at school (with family and school permission), at the ESS's office or another safe, neutral location;
- Being sensitive to the child and family's previous experiences with treatment or other services to overcome any lingering negative feelings or expectations;
- Finding out about the youth's interests and building those activities into shared time between the ESS and adolescent, which provided opportunities to explore alternative outlets for the adolescent and strengthen the relationship between them;
- Planning youth or family-focused activities that were not treatment-focused, such as special event fairs, sports events, campus visits, or holiday parties.

HYP was designed to have two ESS staff stationed at each agency (e.g., Urban League, Hispanic Health Council) at any one time. Over the five-year period of the project, 11 ESSs were hired. Seven ESS staff had to be replaced when they left for other employment opportunities. Replacements for leaving included: being hired by other agencies that had come to appreciate their competencies; need for better pay; and the realization for a few that being an ESS was not a good fit for them. With each change in staff, HYP lost a wealth of informal knowledge of clients that was not well-documented in client files or in the MIS system (e.g., client hangouts, alliances, friends, additional collateral, peers or members). Given the personal nature of the relationships each ESS established with the youth and families, staff turnover led to discontinuities in some clients' transitions from initial contact to treatment engagement and entry.

Client Profile. The HYP initiative was designed to serve the entire Hartford community, especially the large Hispanic and Black neighborhoods in the city. Between March 2003 and June 2007, the ESSs received 360 referrals to HYP. In 21 cases, the ESSs were either unable to contact the referred youth or family or they refused to participate in HYP at the initial meeting with an ESS. Three hundred thirty-three adolescents completed the baseline GAIN assessment, including 209 who went on to receive a treatment recommendation. One hundred ninety (91%) of those referred to an HYP clinical service entered the treatment program. The remaining 19

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**Table 1**: Hartford Youth Project Client Characteristics by Racial/Ethnic Background

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>African American (N = 157)</th>
<th>Hispanic (N = 199)*</th>
<th>Total (N = 356)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>143.5 yrs. (1.2)</td>
<td>147.2 yrs. (1.2)</td>
<td>147.1 yrs. (1.2)</td>
</tr>
<tr>
<td>Single parent</td>
<td>69.8%</td>
<td>76.8%</td>
<td>74.6%</td>
</tr>
<tr>
<td>Substance Use</td>
<td>63.3%</td>
<td>72.6%</td>
<td>68.9%</td>
</tr>
<tr>
<td><strong>Past Year Substance Use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily Use</td>
<td>4.2%</td>
<td>6.0%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Use</td>
<td>64.6%</td>
<td>66.6%</td>
<td>62.8%</td>
</tr>
<tr>
<td>Abuse</td>
<td>22.9%</td>
<td>17.4%</td>
<td>19.6%</td>
</tr>
<tr>
<td>Dependence</td>
<td>8.5%</td>
<td>19.8%</td>
<td>16.8%</td>
</tr>
<tr>
<td>Current Weekly Marijuana Use</td>
<td>80.6%</td>
<td>81.0%</td>
<td>80.8%</td>
</tr>
<tr>
<td>Current Weekly Alcohol Use</td>
<td>49.2%</td>
<td>57.2%</td>
<td>54.0%</td>
</tr>
<tr>
<td><strong>Comparability</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor mental health problem</td>
<td>6.1%</td>
<td>7.7%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Internalizing Problems Only</td>
<td>42.9%</td>
<td>35.0%</td>
<td>37.4%</td>
</tr>
<tr>
<td>Self Inhibition and Externalizing</td>
<td>20.6%</td>
<td>24.8%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Social Disconnection</td>
<td>20.1%</td>
<td>32.6%</td>
<td>28.3%</td>
</tr>
<tr>
<td>Ever Victimized</td>
<td>55.0%</td>
<td>51.2%</td>
<td>53.2%</td>
</tr>
<tr>
<td>Weekly School Absentee in Past 90 Days</td>
<td>40.2%</td>
<td>53.0%</td>
<td>47.1%</td>
</tr>
<tr>
<td>Sexually Active in Past 90 Days</td>
<td>77.6%</td>
<td>75.4%</td>
<td>76.9%</td>
</tr>
<tr>
<td>Multiple Sex Partners in Past 90 Days</td>
<td>41.4%</td>
<td>43.9%</td>
<td>42.9%</td>
</tr>
<tr>
<td>Violent in the Past Year</td>
<td>71.6%</td>
<td>74.6%</td>
<td>73.6%</td>
</tr>
<tr>
<td>Illegal Activity in the Past Year</td>
<td>61.9%</td>
<td>54.7%</td>
<td>58.0%</td>
</tr>
<tr>
<td>Lifetime Juvenile Justice Involvement</td>
<td>95.2%</td>
<td>86.5%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Spent &gt;13 Days in Controlled Environment in Past 90 Days</td>
<td>21.8%</td>
<td>35.8%</td>
<td>29.0%</td>
</tr>
</tbody>
</table>

*Includes 50 cases who were not classified as either African American or Hispanic.

While the ESSs worked hard to keep families engaged in the interim, some clients became incarcerated between assessment and admission or during treatment, or families simply lost interest. In a few instances, the court decided to place youth involved in the juvenile justice system into non-HYP treatment via juvenile justice slots if the HYP treatment admission process was delayed too long.

Of the 190 youth who entered treatment, the majority (59%) were referred by the juvenile justice system, mostly parole and probation officers. The remaining referrals were from DCFS's child welfare office (12%), schools, (10%), self or family (10%), and other sources, including treatment providers and social services agencies (5%). Sixty-five percent of the youth entered MDPOT, 34% MSAT, and 9% FSN. Only 1% received MEPC with direct services to the youth alone. One hundred seventeen (62%) self-identified as Hispanic or Latino. 63 (33%) identified themselves as African American or Black, and 59% were from another racial/ethnic group, including White, Asian and Native American. Table 1 shows the demographic and psychosocial profiles of the Hispanic and Black clients served by HYP. Overall, the average adolescent was 14.7 years of age. Three out of four clients
were males and the majority (60%) of African Americans and 73% of Hispanics) lived in single-parent households. The substance use and environmental risk profiles of these youth were consistent with the largest population HYP had been designed to serve. Most of the adolescents who received treatment services through HYP did not meet substance use disorder criteria at their initial assessment; slightly more than a third (30%) reported sufficient substance-related symptoms that diagnostic criteria for substance abuse or dependence prior to treatment intake. Marijuana was the primary problem substance. Despite the relatively low substance abuse severity, almost all youth reported either co-occurring disorders or severe environmental risks that justified intervention. Approximately seven out of ten clients reported symptoms of internalizing and/or externalizing disorders, and almost half admitted that they had ever been victims, whether physically, emotionally or sexually. Most (95%) of Blacks and 86% of Latinos had a history of juvenile justice involvement, and majorities of youth in both groups admitted engaging in violent or illegal activity in the prior year. More than half (52%) of clients reported being absent from school on a weekly basis. Finally, despite their young age, 77% were sexually active and 43% reported having multiple sex partners within the past 90 days. None of the differences in risk according to the race/ethnicity were statistically significant.

Prior to HYP, the treatment completion rate for DCF-funded outpatient substance abuse treatment services was approximately 30%. The treatment completion rate for HYP was 48% overall, including 12% who were transferred to another level of care.

Case Studies

The two case studies below are representative of the youth and families served by the ESIs from each agency. These cases, written in first person in the voices of the ESIs who composed them, illustrate the range of needs and issues in this population and the strategies ESIs used to bring and keep these youth in treatment.

Case study #1. A fourteen-year-old Puerto Rican male, "Raul," lived in a small apartment in Hartford with his mother, "Jasie," his sister, brother and two aunts (his sister's children). Raul was referred to HYP by a probation officer following charges of marijuana possession, burglary and criminal possession. An appointment was made to assess the teen at my office at the Hartford Health Council, with his mother present in an adjacent room.

During the initial assessment, Raul admitted he had a history of school suspensions due to reckless behavior. He had been using alcohol and marijuana since he was about 11. In the past 90 days he had been smoking marijuana on a daily basis to reduce his boredom and to fit in and have fun. He indicated that his father lived in Arizona and was basically absent from the family. Raul's mother reported, and Raul confirmed, that he was having problems at home as well as at school, including frequent missing curfews, school absences and truancy, and conflicts with his mother and sister. Raul admitted he had a problem with authority and figures like teachers, school counselors, and his probation officer because he believed he was mature enough to do what he pleased. He knew that there were consequences of substance abuse and that he had promised to stop if he did not improve his behavior. He was concerned that his mother could be arrested and the other children placed in DCF custody if his mother was found to have drugs in her house.

Throughout the assessment, I listened to Raul without condemning his behavior or being judgmental. I told him that his personal information would be shared only with those assigned to his care within the Hartford Youth Project. In the end, I gained his trust. I told him that I would take one or two weeks to receive his treatment recommendations, but that I would be in regular contact throughout that time. I shared my office and cell phone numbers with him and encouraged him to call me if any situations arose or if he needed to talk.

I also offered my services to his mother, who spoke limited English. Two days later, Jasie called to advise me that her heat had been turned off for repeated nonpayment. Jasie admitted she was having trouble paying her bills due to a decrease in her scheduled hours at the first food restaurant where she worked. She did not own a car and relied heavily on public transportation, but lacked money for bus fare. I brought the utility assistance paperwork to Jasie and helped her write a request for funds to the "Staircase Fund," my agency's discretionary fund. I also brought her a week's worth of bus tokens so she could get to work. Within five days, my agency was able to provide her a caseworker to help her with her utility bills. After a few weeks, she had located a new job, and the family was not receiving any benefits.

I worked with the DCF worker to get the children new clothes for school. I contacted Center City Churches to obtain some clothing for the client's mother as well. I transported Lucille back to the Urban League so that she could fill out the paperwork to obtain food stamps. In the meantime, I worked with the local food bank to get the family some food. Based on the teenager's weekly substance abuse, the client was referred to Multisystemic Therapy (MST). Lucille also received support from her daughter's school, in the form of extra help and a mentor to help her maintain her attention and interest.

Raul and his family completed treatment with Martha at the Village. Martha reported several improvements: more consistent school attendance, increased communication with his family and his probation officer. Martha and Raul had both his mother and older sister; and more time spent at home, especially during weekends. As a result, Raul's attendance improved and he began to feel more secure in his family environment.

Case study #2. Tamara, a fifteen-year-old African American female, was referred to the Hartford Youth Project as result of truancy and suspected substance use. According to the family's DCF worker, Tamara was skipping school to go to a treatment center. We got in touch with her mother to administer the GAIN-Q to determine her eligibility for HYP. Tamara was dressed in sweatsuits and an oversized t-shirt. She appeared slender and mature for her age, and politely greeted us. In response to the GAIN-Q items, she denied skipping school as well as substance use and any other problem behaviors. Based on her answers to the GAIN-Q, Tamara was not eligible for HYP. But I suspected that she was not being honest with me. I spoke with her mother, "Lucille," who reported that, in addition to skipping school, Tamara had been spending time with friends who smoked weed and had come home with red eyes, smelling of marijuana. Her mother also reported that Tamara had been sexually abused by a male cousin at the age of 12. Even if Tamara was not currently using, she was at risk for substance use because of her peer group and other issues. I asked her to contact Lucille to complete the full GAIN assessment with Tamara to increase Tamara's comfort level. To my concern, Tamara admitted skipping school and having used marijuana weekly, making her eligible for HYP. Tamara disclosed that she skipped school not to get high but because she "has nothing to wear."

I went to the family's home to meet with Lucille. The family lived in a rent-apartment in a three-family house located in a dangerous neighborhood known for drug sales and gang activity. Seeing the condition of the home, and the lack of furniture, I knew that the family had needs beyond substance abuse treatment. Tamara, her siblings (two boys and two girls under the age of 10), and Lucille all needed clothing. There was also an insufficient food supply in the house. Lucille had recently lost her job, and the family was not receiving any benefits.

I worked with the DCF worker to get the children new clothes for school. I contacted Center City Churches to obtain some clothing for the client's mother as well. I transported Lucille back to the Urban League so that she could fill out the paperwork to obtain food stamps. In the meantime, I worked with the local food bank to get the family some food. Based on the teenager's weekly substance abuse, she was referred to Multisystemic Therapy (MST). Lucille also received support from her daughter's school, in the form of extra help and a mentor to help her maintain her attention and interest.
The state agency was responsible for oversight and project management, but it actively collaborated with community-based agencies, treatment providers, and other stakeholders in the project’s development and implementation, building a system-wide buy-in by all stakeholders. With so many agencies involved, role definition and project coordination were crucial for integrating outreach and engagement and treatment services to meet the needs of all stakeholders. The resulting infrastructure was complex but well-developed and supported the ESIs’ success.

Individual characteristics and training are crucial considerations for outreach and engagement. The ESIs staff had a number of personal characteristics that were considered important for their role, including knowledge and comfort in the communities they served, strong interpersonal skills, flexibility, persistence and commitment to improving the well-being of youth and families. To help prepare them for their role, the ESIs received intensive training in substance use issues, treatment modeling, assessment, engagement and motivation strategies, community services and advocacy. At all times they had the guidance and support of the HFY leadership. They also had opportunities to guide adaptations to the outreach and engagement model to enhance its cultural appropriateness and effectiveness. The ESIs, who had minimal or no higher education, became skilled in identifying client needs, planning for services, leveraging and utilizing community resources for clients, and interfacing with service providers.

Overcoming treatment provider reluctance to integrate non-clinical, non-mandatory outreach and engagement workers who were employees of another agency into the treatment intervention was a significant challenge. However, through ongoing dialogue between treatment providers, engagement workers, staff, and project management, a collaborative approach was developed in which ESIs became instrumental liaisons between the providers and the families, providing crucial case management and other services as a family-oriented wraparound to the evidence-based models.

The family focus of HFY was both an asset and a challenge for engaging and retaining adolescents in treatment. A family-focused treatment approach for adolescents with substance abuse problems is considered a best practice, especially when used with families of color (Liddle et al., 2006; Boyd-Franklin, Morris & Roy, 1997). According to Walker and Schotte (2004), for a family-driven process to be successful in a system of care, structures and supports must be in place and responsive to client needs but also open to family participation and preferences, incorporate and encourage family strengths, and allow adjustments due to changing family situations. HFY’S approach addressed the needs of the whole family rather than just those of the adolescents, but it also depended on the active participation of parents/caregivers as well as the youth. There were numerous barriers to obtaining family buy-in and participation in treatment, including reluctance to participate in the “child’s” treatment, resistance to having strangers come into the home, concerns about vulnerability to legal or child welfare problems, and insufficient concern about the child’s substance abuse use. Given these types of challenges to implementing HFY’s family-centered services, it is important to consider the future research, as well as policymakers and program developers, to systematically assess the barriers to family-focused models for adolescent substance abuse treatment and how the delivery system can be improved.

Another initial challenge was the cultivation of community-based referred sources. Schools in particular were reluctant to refer adolescent substance abuse treatment due to concerns about confidentiality and the perceptions of the HAP approach, student confidentiality, and the stigma associated with substance abuse treatment. Referral sources also had limited resources for referrals since they had an ascendant approach to getting substance-abusing youth into treatment, even though they welcomed its family-focused services. The ESIs had to work hard to cultivate relationships with and build the trust of referral sources, using presentations, printed materials, media interviews and ongoing contacts, as well as the HFY’S increasingly positive reputation in the community, to convince school and community personnel of its value.

Other challenges were inherent in the ESIs’ role within the system of care, which included marketing, outreach, assessment, treatment planning, advocacy, case management and data collection. Because of the pressures and time demands of these multiple responsibilities and a large caseload, the ESIs required close supervision, crisis management and daily support. The need for specialized supervisory structures and the multi-agency design of HFY sometimes made accountability and support functions disjointed and inefficient. Strategies that maximized the ESIs’ access to ongoing supports and clear direction included integrating agency-level supervisors into regular project meetings and establishing benchmarks that were reported regularly to keep everyone up-to-speed on the ESIs’ accomplishments and any problems they encountered in the field.

These job-related pressures, the intense nature of the work, and the limited recovery compensation allocated to outreach and engagement continue to be staff turnover among ESIs. Given the comprehensive and intensive nature of the ESIs role and its dependence on building trusting relationships with clients and families, staff turnover threatens the continuity of contact and care for the clients. Inservice ESIs had to work hard to reconstruct informal client information and rebuild relationships. More systematic documentation of client information and case-sharing were identified as two ways of promoting continuity of both information and client care in the face of staff turnover.

Sustainability of the outreach and engagement component of HFY was a particular concern for the DCF team on the HFY experience, DCF was able to justify allocation of state resources to expand intensive in-family-based models like MST and MDPT statewide. However, finding stable financial support for outreach and engagement models was more problematic. Because the ESIs were unlicensed, most of the services they provided through HFY were not eligible for cost reimbursement by public or private insurance as most clinical service providers are. This has been a disincentive to many management services the treatment program offered. DCF did have success in sustaining the ESIs via state-level funding for the state’s public health initiative for adolescent substance abuse treatment. However, the long-term sustainability prospects in the absence of insurance reimbursement remain uncertain, and support via customary funding options will require development of a well-articulated evidence-based outreach and engagement model.

HFY’S goals were to increase access and engagement in adolescent substance abuse treatment. The project exceeded its service objectives in both the number served and in improving treatment discharge outcomes from historical state levels. The rate of successful discharges (clients who either completed treatment or were transferred to another level of care for HFY) was not different from the national rate of positive treatment discharges (48% in HFY compared to 47% found in the national Treatment Episode Database; OAS 2005). Future research is needed to quantitatively determine the impact of HFY in improving access to treatment and effectiveness over standard practices, and the conditions under which outreach and engagement is most likely to be needed or successful. It is possible that outreach and engagement services are more critical to treatment effectiveness with modalities that do not include intensive case management or in-home services, or are more appropriate for minority and socioeconomically disadvantaged populations who have multiple needs but limited access to supportive resources.

REFERENCES


Predictors of Early Therapeutic Alliance Among Adolescents in Substance Abuse Treatment†


Abstract—Given the importance of the therapeutic alliance in achieving positive treatment outcomes, research is needed to illustrate the factors that contribute to the development of this important relationship. The aim of the current study was to expand upon the existing literature by examining predictors of the early therapeutic alliance among adolescents treated in two inpatient programs. Use of multilevel modeling techniques revealed that the majority of the variance in alliance scores was not attributable to adolescent and therapist factors (52% vs. 48%). Participating age was found to be the only significant predictor of therapist-adolescent alliance, with therapists reporting higher alliances with older adolescents. Adolescents reporting higher levels of social support, greater problem recognition, and more sources for quitting also reported higher therapeutic alliance ratings. Future research is needed to examine if early identification of adolescents with low social support and problem recognition combined with skill-oriented intervention strategies can be a promising approach to help improve therapeutic engagement and post-treatment substance use outcomes.

Keywords—adolescent, substance abuse, therapeutic relationship, working alliance

Engagement in treatment has been identified as one of the nine principles of effective adolescent drug treatment (Drug Strategies 2003). Therapeutic alliance, broadly defined as "the collaborative and affective bond between therapist and patient" (Martin, Garske & Davis 2000: 438) is an important component related to treatment outcomes. This construct has long been recognized within the field of psychotherapy (Carkhuff, 1969; Rotter & Wilbers, 2004; Horvath & Symonds, 1991; Orlinsky & Howard, 1986, Greenberg & Treff, 1993) and has been the subject of much research within the substance abuse treatment speciality (Simpson 2004; 2001; Barber et al, 2001; Joe et al., 2001; Bent, Montoya & Akkinni, 1997; Crtaro & et al., 1997). While research evaluating the relationship of therapeutic alliance with treatment outcomes is often limited to adult patients, there are few studies, especially in the adolescent substance abuse treatment setting, which focus on the relationship between therapeutic alliance and treatment outcomes.